OMB No: 0930-0168
Approval Expires:07/31/2007

TRANSFORMING MENTAL HEALTH CARE IN AMERICA

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT APPLICATION GUIDANCE AND INSTRUCTIONS FY 2007

CFDA No. 93.958

Upon enactment of the President's FY 2007 Budget, States will be required to modify the FY 2007 plan to describe transformation activities and appropriate outcome measures that are consistent with the FY 2007 appropriations language.

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

TABLE OF CONTENTS FOR APPLICATION GUIDANCE PACKAGE

Notice to Respondents

The annual reporting burden for collection of this information is estimated to average 3*20* hours for a one-year application, 2*90* hours for updating a two-year plan, and 25*9* hours for updating a three-year application. This includes the time required for reviewing instructions and preparing the application, requesting waivers and modifications, writing the implementation report, and gathering, maintaining, and reporting the needed data. Comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden should be addressed to: SAMHSA Reports Clearance Officer, Paperwork Reduction Project (0930-0168), Room 7-1045, One Choke Cherry Road, Rockville, MD 20857. An agency may not conduct or sponsor or a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is: 0930-0168.

INTRODUCTION:

The FY 2007 Community Mental Health Services (CMHS) Block Grant Application Guidance and Instruction Packet that follows is intended to provide specific guidance and instructions regarding the development and submission of the required plan. The Guidance is based on the existing CMHS Block Grant legislation and provides a foundation for further transformation of the state mental health system. The existing five (5) criteria continue to be the framework for the mental health system of care and should be used to guide State planning efforts. There continues to be an emphasis on the reporting and use of the National Outcome Measures (NOMS).

States should submit the FY 2007 plan based upon the standard guidance in this instruction packet. States will not be required to address transformation as described below and in the FY 2007 appropriations language until the appropriations language becomes law. For this purpose, any reference made to the requirement for States to describe and report transformation activities in this application guidance and instructions will be provided in bold print.

Should the President's FY 2007 Budget be enacted, States will be required to modify the FY 2007 plan to describe transformation activities and appropriate outcome measures that are consistent with the FY 2007 appropriations language. See FY 2007 appropriations language in Appendix IV. This Application Guidance is written to be consistent with the President's FY 2007 Budget request for priority funding mental health transformation through the Mental Health Block Grant. The budget request requires States to use a portion of its Block Grant allotment to fund mental health transformation activities and to report to CMHS annually on the use of the funds and to report on the outcomes of transformation activities. Additionally, the Guidance provides a structure to identify and highlight state-specific transformation activities, both infrastructure development and services, planned and implemented by the State Mental Health Authority.

<u>The Federal Action Agenda: First Steps</u> defines transformation as "a bold vision to change the very form and function of the mental health service delivery system to better meet the needs of the individuals and families it is designed to serve". Transformation of State mental health systems encompasses a process that occurs in a non-linear fashion that requires

collaboration, innovation, sustained commitment, and willingness to learn from past mistakes. Transformation has implication for policy, funding and practice as well as attitudes and beliefs, is a continuous process that leads to profound change in structure, culture, policy and programs, and grounded in principles that are both consumer and family driven and focuses on facilitating recovery and resilience.[1]

Examples of State transformation activities: 1) a traditional day treatment program that moves into supported employment and onto competitive employment; 2) a partial hospitalization program that transitions into a community stabilization/mobile treatment team; 3) the initiation of peer support services as a demonstrated method of community integration and means of building social relationships; and, 4) in rural communities where workforce shortages have existed, specialized training may be provided to support use of telemedicine as an effective means of providing mental health treatment.

Other examples of transformation activities are referenced in the Report of the President's New Freedom Commission on Mental Health and include but are not limited to activities directed toward:

- ***reduction of the stigma associated with mental illness;***
- ***suicide prevention***
- ***linking mental health care with primary care***
- ***improving coordination of care among multiple systems***
- ***assuring individualized plans of care for all consumers***
- ***facilitating consumers' access to employment and affordable housing***
- ***development of culturally competent services***
- ***removing disparities in access to and quality of care***
- ***provision of Evidence Based Practices***
- ***addressing needs of workforce***
- ***aligning financing for mental health services for maximum benefit.***

1 Transforming Mental Health Care in America (2005). The Federal Action Agenda: First Steps. DHHS Pub. No. SMA-05-4060. Rockville, MD: Department of Health and Human Services.

The Application Guidance and Instructions Packet consist of five parts:

- Part A provides a context and overview of the FY 2006 – 2007 application with a more detailed discussion of the transition to performance partnerships.
- Part B outlines the administrative requirements, fiscal planning assumptions, and other special guidance that is required for submission of the application.
- Part C provides guidance for development of the three sections of the plan, including a description of the State's Service System, Identification and Analysis of the Service System's Strengths, Needs, and Priorities, Mental Health Transformation Activities, and Performance Goals and Action Plans to Improve the Service System for adults and children separately.
- Part D gives guidance for preparation and submission of the Implementation Report which is used to describe the extent to which the State has implemented its prior year plan.
- Part E provides guidance on submission of the Basic and Developmental Data Tables from the Uniform Data Reporting System.

There are also several required attachments and several appendices that provide useful resource information needed for the plan.

PART A: CONTEXT AND OVERVIEW OF FY 2006-2007 CMHBG APPLICATION

I. Statutory Authority

Under the authority of the Public Health Service Act (PHS Act)[2] and subject to the availability of funds, the Secretary of the Department of Health and Human Services, through the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), awards Block Grants to States to establish or expand an organized community-based system for providing mental health services for adults with serious mental illness (SMI) and children with serious emotional disturbances (SED). In order for the Secretary to award these Block Grants, States, Territories and the District of Columbia (herein after referred to as States) are required to submit an application, prepared in accordance with the law, for each fiscal year for which the State is seeking funds. The funds awarded are to be used to carry out the State plan contained in the application, to evaluate programs and services set in place under the plan, and to conduct planning, administration and educational activities related to the provision of services under the plan.

Specific authority for requiring data from the States is found in three different Sections of the law. First, the Secretary is required to establish definitions for SMI and SED.[3] Second, in order to receive funding, States will provide to the Secretary any data required pursuant to Section 505, and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section. [4] Third, the application (including the plan under Section 1912(a)), must be otherwise in such form, made in such manner, and contain such agreements, assurances, and information as the Secretary determines to be necessary to carry out this subpart.[5] A grant may be made only if the plan meets the five (5) criteria in the law and is approved by CMHS. [6] After review of the State plan implementation report for the previous fiscal year, CMHS must also determine that the State has completely implemented the plan approved for the previous fiscal year.

---

2. Sections 1911-1920 and 1941-1954 of the Public Health Service Act (PHS Act)
3 Section 1912(c)(1) and (2) (42 U.S.C. 300x-2)
4. Section 1943(a)(3) (42 U.S. C. 300x-53)
5. Section 1917(a)(7)
6. Section 1912 (b)

II. History and Goals of Federal Mental Health Funding and Planning Requirements

Federal financial support of mental health programs has gone through many transitions from its beginning in 1963 with passage of the Community Mental Health Centers legislation to provide comprehensive services in local communities, [7] through conversion to block grants in 1981, and passage of legislation in 1986 and 1990 requiring states to develop and enhance comprehensive community-based systems of care.[8] In 1992, Congress passed legislation that moved responsibility for administration of the mental health block grant and state planning requirements from the National Institute of Mental Health to the newly formed Center for Mental Health Services, part of the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services. Finally, in 2000, legislative changes allowed states more flexibility in the use of block grant funds. [9]

Over the past 20 years, the evolution of policy changes which tie the mental health block grant funds to the development and implementation of state plans has had the following key goals:

- Access to a comprehensive system of care, including employment, housing, case management, rehabilitation, dental and health services, along with mental health services and supports;
- Participation of consumers/survivors and their families in planning and evaluation of state systems;
- Access for underserved populations, including homeless people and rural populations;
- Promoting recovery and community integration of people with psychiatric disabilities; and,
- Accountability through uniform reporting on access, quality, and outcomes of services.

These goals have been reaffirmed in recent years by several key federal developments: the Surgeon General's Report on Mental Health (1999); the New Freedom Initiative for People with Disabilities (2001); and the report of the New Freedom Commission on Mental Health (2003).

---

7. Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America*. Princeton, NJ: Princeton University Press, 1991, 113-114.
8. Joseph N. De Raismes, III, *The Evolution of Federal Mental Health Planning Legislation*. http://www.namhpac.org/pages/bckground/back_evolution.html
9. De Raismes, http://www.namhpac.org/pages/bckground/back_evolution.html

These documents emphasize the importance of access to work, housing, rehabilitation, and other services which support integration into the community for people with psychiatric disabilities, as well as the other goals listed above.

The President's New Freedom Commission on Mental Health was charged to study the problems and gaps in the mental health system and make concrete recommendations for immediate improvements that the Federal government, State governments, local agencies, as well as public and private health care providers could implement. The vision of the Commission was "a future when everyone with a mental illnesses will recover, when mental illnesses can be prevented or cured, when mental illnesses are detected early, and when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning, and participating fully in the community. The Commission was formed to propose an agenda to transform mental health care, which included the expansion of access to mental health services; promotion of evidence based practices, more early assessment and treatment; and consumer and family driven mental health care. The July 2003 Final Report of this Commission, entitled "Achieving the Promise: Transforming Mental Health Care in America," acknowledges that the public mental health system is fragmented and in disarray, and does not fulfill the promise of a meaningful life in the community for people with psychiatric disabilities. The Report recommends six broad goals for a transformed public mental health system that would promote recovery:

1) Americans understand that mental health is essential to overall health;
2) Mental health care is consumer and family- driven;
3) Disparities in mental health services are eliminated;
4) Early mental health screening, assessment and referral are common practice;
5) Excellent mental health care is delivered and research is accelerated; and,
6) Technology is used to access mental health care and information.[10]

Each of these major goals has sub-goals; Goal 2, "Mental health care is consumer and family-driven," has as one of its sub-goals a call for more attention to comprehensive state mental health planning, and a call for more accountability, not just to federal funders, but to consumers and families as well.

10. The President's New Freedom Commission on Mental Health, 5-6.

Recognizing that "in the past decade, mental health consumers have become involved in planning and evaluating the quality of mental health care and in conducting sophisticated research to affect system reform," the Report goes on to recommend that "local, state, and federal authorities must encourage consumers and families to participate in planning and evaluating treatment and support services. The direct participation of consumers and families in developing a range of community-based, recovery-oriented treatment and support services is a priority."[11]

11. The President's New Freedom Commission on Mental Health, 18.

III. Planning Initiatives

The release of "Achieving the Promise: Transforming Mental Health Care in America," is a critical and significant development at the national level; and it is proving to be formative to the planning and goals of the Mental Health Block Grant (MHBG). In July 2005, SAMHSA/CMHS announced another major planning initiative to focus on the collaboration among twenty-one (21) Federal agencies to support and foster transformation of the nation's mental health system. This initiative is described in the publication titled "The Federal Action Agenda: First Steps." These developments support models for a comprehensive, community-based system of care for individuals with serious mental illness, the ultimate goal of the MHBG.

The most recent initiative is a component of the President's FY 2007 Budget that proposes Federal support to States through the MHBG for mental health transformation. The budget language proposes the following ..." States that receive an allotment for the current fiscal year shall use any amount it receives in fiscal year 2007 which is in excess of what it received under such section in 1998 to support mental health transformation activities such as the expansion of access, advancement of evidence based practices, promotion of early assessment and treatment, and promotion of consumer and family driven mental heatlh care. A State that receives an allotment under section 1911 will report annually to SAMHSA on its use of funds and the outcomes of mental health transformation activities." See FY 2007 appropriations language in Appendix IV.

Accountability in the delivery of quality mental health services for adults with serious mental illness and children with serious emotional disturbance continues to be an integral part of the planning process and will be measured by the collection of standardized data from the States using uniform outcome measures (NOMS) and other measures specific to mental health services as determined by the individual States according to their priorities and needs. The NOMS are shown in Table 4 and are derived from the Uniform Reporting System (URS) set of Basic and Developmental Tables located in Appendices I and II.

These tables also serve as the basis for the Data Infrastructure Grants (DIG) that were first offered to States and Territories in FY 2001 to provide funding to improve their data collection

activities that would result in reporting uniform data that could be aggregated on a national basis. CMHS, working with the States and Territories, are operationalizing the measures included in the data tables through monthly meetings of CMHS program staff and staff from the States.

All States and Territories that accepted a DIG are required to submit data on the URS tables consistent with the work that has been accomplished in the DIG including using the uniform definitions and methods agreed to by the States and Territories. Likewise, the measures that States and Territories will use for reporting and planning purposes in their State plans should be consistent with and reflect the data reported in the related URS table. Lastly, as the work progresses under the DIG, States will be expected to begin reporting those items. Instructions and expectations regarding the actual reporting and implementation of NOMS that are currently under development will be transmitted separately.

The inclusion of a focus on specific activities directed toward transformation of the State mental health system in the FY 2007 Application Guidance and Instructions continues the transformation of the mental health block planning process. This focus, in addition to the partnership with State Mental Health Authorities (SMHA), will lead to the development of a comprehensive plan that will advance the goals and recommendations of the Report of the President's New Freedom Commission on Mental Health and will result in a service system that is consumer driven and based on the principles of recovery and resilience.

IV. Plan Format: Child/Adult Plans; One Year and Multi-Year Plans

Under Section 1912(b) of PHS Act (42 USC 300x-2), the State Plan must address the five (5) legislated criteria. Criteria 1, 2, 4 and 5 must be addressed for adults with SMI, and Criteria 1-5 must be addressed for children with SED. States should submit a single plan in which services for both adults with SMI and children with SED are addressed separately. ***Upon enactment of the President's FY 2007 Budget, States will be required to submit a modified plan, which describes transformation activities and appropriate outcome measures (see attached FY 2007 appropriations language.***

(1) Application Overview for Single Year Plans in 2007

In preparing State Plans for FY 2007 (due September 1, 2006), States should use this Application Guidance and Instructions. The application must include a Face Sheet, a Table of Contents, an Executive Summary, and all items required in Part B, Part C (Sections I-III). The implementation report (Part D & E), due December 1, 2006, will describe the extent to which the State implemented its mental health plan for FY 2006 and will include data from the Uniform Reporting System (URS Tables).

The plan (Sections I-III) must address each element of the four (4) criteria for adults and five (5) criteria for children as enumerated in the block grant legislation. ***Mental health transformation activities to be included in the planning process should be added within the specific criterion to which they relate.*** The plan should contain goals and targets for the NOMS. States that received approval to exclude funds from the maintenance of effort calculation should include those MOE approval documents, as well. If changes occur during the year that affects the plan as submitted to CMHS, States may submit a modification of the Plan to CMHS. States are also reminded that criterion 5 requires information on how the grant will be expended and a funding plan.

(3) Guidance Specific to Two or Three-Year Plans Approved in FY 2005 and 2006

States that were approved for three year plans in FY 2005 and/or two year plans in FY 2006 will be required to submit all items in Part B. Under Part C, Section I will not need to be re-submitted unless the State's public mental health system has substantially changed and/or the

State Mental Health Agency's authority changes within the State's organizational structure. Only modifications and changes to Sections II and III must be submitted with the State's application, and should describe changes in critical gaps and unmet needs, identify significant achievements reflecting progress towards development of a comprehensive community-based mental health system, and document any changes in the original goals and targets.

States that were approved for three year plans in FY 2005 and/or two year plans in FY 2006 must submit adequate narrative to describe the State's mental health transformation activities. Additionally, multi-year plans are required to provide a description of how the State plans to use its allotted MHBG funds to support mental health transformation activities, include at least one State transformation outcome measure and report the amount of Block Grant funds expended for mental health transformation activities during the fiscal year. (See Appendix II for list of transformation activities and services).

All performance indicator tables must be updated each year to include narrative as needed. States that submitted two-year plans in 2006 are expected to ensure that their plans are updated to reflect the current status of their mental health systems. ***State mental health transformation outcome measures in the 2007 State plan must be clearly labeled.***

It is important that the MHBG Program be notified of changes made in the State's mental health system after the Plan has been submitted through written modification submitted to SAMHSA's Division of Grants Management Office. Before submitting applications each year, States should assess the impact of any positive or negative changes that occurred in the previous year that will affect the State's ability to carry out the proposed plan. If changes are necessary, States may modify the plan as part of the application package (thus modifying the original plan). In modifying previously approved plans, States should identify specific changes referring to page numbers of the original plan, rather than simply making changes to the original plan and resubmitting it. These modifications should be discussed in detail within the context of the affected criteria, goals, and targets and submitted to SAMHSA's Division of Grants Management Office.

PART B. ADMINISTRATIVE REQUIREMENTS, FISCAL PLANNING ASSUMPTIONS, AND SPECIAL GUIDANCE

I. FEDERAL FUNDING AGREEMENTS, CERTIFICATIONS AND ASSURANCES AND REQUIREMENTS

Federal funding agreements, certifications, assurances and other requirements are necessary each year in order for States to receive mental health block grant funds.

(1) FUNDING AGREEMENTS (Attachment A)

Do not retype the Funding Agreement; this may require re-submission of the agreement which could delay the award of funds. The Chief Executive Officer (Governor) or a formal designee must sign the statutory funding agreements, hereby attesting that the State will comply with them. If the funding agreements are signed by a designee, a letter from the Governor authorizing the person to sign must be included with the application.

(2) CERTIFICATIONS – PHS 5161-1 (Attachment B) - (OMB Approval 0920-0428)

Do not retype any of the certifications; this may require re-submission of a certification, which could delay the award of funds.

(a) Debarment and Suspension

A fully executed Debarment and Suspension Certification must be included.

(b) Drug-Free Workplace Requirements

A fully executed certification regarding Drug-Free Workplace Requirements must be included with the application unless the State has an acceptable FY 1997 Statewide or Agency-wide certification on file with the Department of Health and Human Services. Federal regulations regarding these requirements are found in 45 CFR Part 76.

(c) Lobbying and Disclosure

A fully executed Lobbying Certification must be included for all awards exceeding $100,000. This certification must be signed by the Chief Executive Officer of the State (Governor) or his/her formally authorized designee. Additional information about this requirement can be found in 45 CFR Part 93.

Included in the FY 2007 Application Guidance and Instructions is a copy of Standard Form-LLL "Disclosure of Lobbying Activities" and instructions to report lobbying activities.

(d) Program Fraud Civil Remedies Act (PFCRA)

(e) Environmental Tobacco Smoke

(3) ASSURANCES SF 424B (Attachment C) - (OMB Approval 0348-0040)

Do not retype any of the assurances; this may require re-submission of the assurance(s), which could delay the award of funds.

(4) DATA UNIVERSAL NUMBERING SYSTEM (DUNS) NUMBER

A DUNS number is a unique 9-digit number required for all applicants for Federal grants and cooperative agreements, with the exception of individuals other than sole proprietors. The number is used to identify related organizations that receive funding under grants and cooperative agreements, and to provide consistent name and address. The DUNS Number should be entered on the Face Sheet of the State's Plan/Application.

(5) PUBLIC COMMENT ON THE STATE PLAN

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. States should describe their efforts and procedures to obtain public comment on the plan in this section.

II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances (SED).[12] Each year the State shall expend not less than the calculated amount for FY 1994.

Data Reported by:

State FY _____ **Federal FY_____**

State Expenditures for Mental Health Services

Calculated FY 1995	**Actual FY 2005**	**Estimate/Actual FY 2006**
$ _____	$ _____	$ _____

Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the State may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

III. MAINTENANCE OF EFFORT (MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements.[13] MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

12. Section 1913(a) of the PHS Act
13. Section 1915(b)(1) of the PHS Act

MOE Exclusion

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. [14] States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

MOE information reported by:

State FY _____ **Federal FY_____**

State Expenditures for Mental Health Services

Actual FY 2004	**Actual FY 2005**	**Estimate/Actual FY 2006**
$_____	$_____	$_____

14. Section 1915(b)(2) of the PHS Act

MOE Shortfalls

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall. These conditions are described below.

(1). Waiver for Extraordinary Economic Conditions

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

(2). Material Compliance

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

IV. Fiscal Planning Assumptions

For FY 2007, States are expected to develop their intended use of funds based on their FY 2006 Mental Health Block Grant allocation. ***However, upon enactment of the President's FY 2007 Budget, States will be required to submit a modified plan that provides a description of how the State plans to expend the mental health block grant funds based on the FY 2007 State Allocations and FY 1998 Actuals required for mental health transformation activities. (See Allocation Table for Transformation funding in Appendix V).*** Funds awarded under this Block

Grant must be obligated and expended within the two-year period. For the FY 2007 block grant award, the period is October 1, 2006 through September 30, 2008. States are also required to submit a Financial Status Report (SF 269 Short Form) 90 days after the end of the obligation and expenditure period which is December 31, 2008.

V. Submission Requirements and Due Dates

Please submit an original application plus two copies to Ms. LouEllen M. Rice, Grants Management Officer, Division of Grants Management, OPS, SAMHSA, 1 Choke Cherry Road,, Room 7-1091, Rockville, Maryland 20857 (for overnight/express mail, use zip code "20850". Parts B and C (Sections I, II, & III) of the State plans/applications are due on September 1, 2006, and Parts D (Implementation Report) and E (Uniform Reporting System) are due December 1, 2006. These are statutorily set due dates and waivers cannot be given. [15] If your State application and Implementation Report are not received in the Office of Grants Management by these mandatory dates, it will be impossible for your State to obtain a grant for the year indicated.

Detailed guidance and instructions for each section of this application are provided. Upon request, CMHS will supply a 3.5" MSWord disk containing the application guidance and instructions. The application is available at the SAMHSA web site as www.mhbg.samhsa.gov. With the exceptions of the Federal Agreements, Certifications and Assurances, all parts of the application may be completed electronically and e-mailed to Deborah Baldwin, Project Officer, State Planning and Systems Development Branch, at deborah.baldwin@samhsa.hhs.gov. If the application is sent electronically, the signed original and two copies of Part B, **and** the original Mental Health Planning Council comments signed by the Chairperson, must be submitted to Ms. Rice by the due date. Should you need additional information regarding submission of the application, contact Ms. Rice at (240) 276-1404. Should you have programmatic questions, contact your Federal Project Officer at (240) 276-1760.

It would be helpful to have a copy of each State's plan sent electronically to expedite the Block Grant review process. Copies should be emailed to deborah.baldwin@samhsa.hhs.gov.

15. As required by Section 1917(a)(1) (42USC 300x-6) of the PHS Act

The original and two (2) copies should be submitted unbound, without staples, paper clips or fasteners. Do not attach or include anything folded, pasted, or in a size other than 8½" x11" on white paper. Heavy or lightweight paper should not be used, and submissions should be printed only on one side. Do not condense type closer than 15 characters per inch. Each sheet of the application should be numbered consecutively from beginning to the end (for example, page 1 for the face sheet, etc.). If appendices or additional materials are included, they should be numbered continuing the same sequence. It is recommended that the State plan be limited to 120 pages; if the application exceeds 120 pages and /or is bound, please provide 10 copies.

VI. STATE MENTAL HEALTH PLANNING COUNCIL

(1). Membership Requirements

State Mental Health Planning Councils are required to conform to certain membership requirements. [16] This includes representatives of certain principal State agencies;[17] other public and private entities concerned with the need, planning, operation, funding and use of mental health services and related services; adults who are current or former consumers of mental health services; family members of adults with serious mental illness and children with serious emotional disturbances, and representatives of organizations of individuals with mental illness and their families and community groups advocating on their behalf. Specifically, the law stipulates that not less than 50% of the members of the planning council shall be individuals who are not State employees or providers of mental health services. The law also requires that the ratio of parents of children with SED to other members of the Council be sufficient to provide adequate representation of such children in the deliberations of the Council.

16. Section 1914(c) of the PHS Act
17. The principal State agencies are: Mental Health, Education, Medicaid, Vocational Rehabilitation, Housing, Social Services and Criminal Justice.

(2). State Mental Health Planning Council Membership List and Composition

To demonstrate compliance with the statutory membership requirements, Tables 1 and 2 should be completed for the current fiscal year. In the Table 1 column, "Type of Membership," indicate whether a member is a consumer, a family member of a child with SED, a family member of an adult with SMI, a provider, a state employee, or a representative not otherwise stated in the legislation.

(3). Planning Council Charge, Role and Activities

State Mental Health Planning Councils are required to perform certain duties.[18] If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

- reviewing plans and submitting to the State any recommendations for modification
- serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems,
- monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.[25]
- the role of the Planning Council in improving mental health services within the State.

In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III.

(4). State Mental Health Planning Council Comments and Recommendations

With the Plan submission, States are required to submit documentation that the State Plan was shared with the Planning Council. Any comments and recommendations to the State plan received from the Planning Council must be submitted, regardless of whether the State has accepted the recommendations. In the annual implementation report, States are also required to submit documentation that the State Plan was shared with the Planning Council and must include

18. Section 1914(b) of the PHS Act (42 U.S.C. 300x-4)

any comments from the Council on the State's annual implementation report. The documentation, preferably in a letter signed by the Chair, should indicate that the Council has reviewed the State plan and the annual report with particular attention to the transformation activities that are highlighted and specified in the plan.

TABLE 1. List of Planning Council Members

Name	Type of Membership*	Agency or Organization Represented*	Address, Phone & Fax

*Council members should be listed only once by type of membership and agency/organization represented. See type of membership in Table 2.

TABLE 2. Planning Council Composition by Type of Member

Type of Membership	Number	Percentage of Total Membership
TOTAL MEMBERSHIP		
Consumers/Survivors/Ex-patients (C/S/X)		
Family Members of Children with SED		
Family Members of Adults with SMI		
Vacancies (C/S/X & family members)		
Others (Not state employees or providers)		
TOTAL C/S/X, Family Members & Others		
State Employees		
Providers		
Vacancies		
TOTAL State Employees & Providers		

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State employee and provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services.

PART C. SPECIFIC GUIDANCE FOR STATE APPLICATIONS AND PLANS

SECTION I. Description of State Service System

In this section, States are requested to identify issues or initiatives within the State that are important in understanding the State plan in the context of the broader system. The section should include:

- An overview of the State's mental health system: a brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.
- A brief summary of areas identified by the State in the previous State plan as needing particular attention, including the significant achievements in its previous fiscal year.
- New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.
- Legislative initiatives and changes, if any.
- A brief description of regional/sub- State programs, community mental health centers, and resources of counties and cities, as applicable, to the provision of mental health services within the State.
- A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

SECTION II. Identification and Analysis of the Service System's Strengths, Needs and Priorities

This section should be written primarily in narrative form with separate discussions of services for adults and children. In preparing the discussions, each presentation should be organized so that it follows the five criteria established in law. Within the discussion, States should separately address the following:

- A discussion of the strengths and weaknesses of the service system;
- An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them
- A statement of the State's priorities and plans to address unmet needs.

- A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.
- A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

States are requested to integrate the discussion of mental health transformation activities into the broader description, identification, and analysis of the service system's strengths, needs, and priorities using the goals from the Report of the President' New Freedom Commission to structure the discussion.

Table 3.

Statutory Criteria and Transformation Activities to be addressed in the State Plan.

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

- Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:
  - Health, mental health, and rehabilitation services;
  - Employment services;
  - Housing services;
  - Educational services;
  - Substance abuse services;
  - Medical and dental services;
  - Support services;
  - Services provided by local school systems under the Individuals with Disabilities Education Act;
  - Case management services;
  - Services for persons with co-occurring (substance abuse/mental health) disorders; and
  - Other activities leading to reduction of hospitalization.

- ***Describes mental health transformation activities in the State in Criterion 1, providing reference to specific goal(s) of the NFC Report to which they relate.***

Criterion 2: Mental Health System Data Epidemiology

- Contains an estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children; and
- Presents quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

- ***Describes mental health transformation activities in the State in Criterion 2, providing reference to specific goal(s) of the NFC Report to which they relate.***

Criterion 3: Children's Services

- Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:
  - Social services;
  - Educational services, including services provided under the Individuals with Disabilities Education Act;
  - Juvenile justice services;
  - Substance abuse services; and
  - Health and mental health services.

- ***Describes mental health transformation activities in the State in Criterion 3, providing reference to specific goal(s) of the NFC Report to which they relate.***

Criterion 4: Targeted Services to Rural and Homeless Populations

- Describes State's outreach to and services for individuals who are homeless;

- Describes how community-based services will be provided to individuals in rural areas

- ***Describes mental health transformation activities in the State in Criterion 4, providing reference to specific goal(s) of the NFC Report to which they relate.***

.

Criterion 5: Management Systems

- Describes financial resources, staffing and training for mental health services providers necessary for the plan.
- Provides for training of providers of emergency health services regarding mental health.
- Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved, *to include a description of how funds will be expended for mental health system transformation. (See Transformation Reporting Form)*
- ***Describes mental health transformation activities in the State in Criterion 5, providing reference to specific goal(s) of the NFC Report to which they relate.***

Note: Criteria 1, 2, 4 and 5 must be addressed in the Adult Plan; Criteria 1-5 must be addressed in the Children's Plan.

Note: ***The identified transformation activities should be consumer and family driven, recovery and resilience based, and as much as possible, utilize existing evidence-based and promising practices including approaches that are consumer owned and operated.***

A number of examples of such activities are referenced in the Report of the New Freedom Commission on Mental Health and include but are not limited to activities directed toward:

- ***reduction of the stigma associated with mental illness***
- ***suicide prevention***
- ***linking mental health care with primary care***
- ***improving coordination of care among multiple systems***
- ***assuring individualized plans of care for all consumers***
- ***facilitating consumers' access to employment and affordable housing***
- ***development of culturally competent services***
- ***removing disparities in access to and quality of care***
- ***provision of Evidence Based Practices***
- ***addressing needs of workforce***
- ***aligning financing for mental health services for maximum benefit.***

SECTION III: Performance Goals and Action Plans to Improve the Service System

1. Common Requirements for Adult and Child Plans

SAMHSA, in partnership with the States, identified data to be used to develop performance indicators that will increase accountability and demonstrate on a state-by-state basis whether community-based services lead to better outcomes for people served. SAMHSA has identified a set of National Outcome Measures (NOMS) that States are expected to integrate into their Mental Health Block Grant planning process.

This section should be organized in the same way as Section II above, with separate discussions of services for adults and children and organized so that it follows the five criteria, including the new prompts for transformation activities. Rather than focusing on strengths, needs and priorities, this section will focus on specific performance goals and action plans. State plans should include a description in narrative form of current activities in the context of the five required criteria as well as goals, targets, and action plans for the appropriate criterion using the NOMS (see Table 4 below), as well as any state-specific indicators they may choose. The State information will include specific performance goals and a description of how the State intends to achieve the performance goals. States may continue to develop and maintain state-specific performance indicators that they find useful for tracking improvements in the public mental health system. More detailed instructions for incorporating the narrative for the five required criteria and the performance indicators are presented in the instructions for the Adult and Child Plan below.

2. National Outcome Measures

For each of the 5 criteria, States should continue to develop, maintain and report on state-specific performance indicators that they find useful for tracking improvements within the State and transformation of the mental health system, in addition to incorporating the NOMS discussed above. States should provide information on these indicators, including specific performance goals, target performance levels, and a description of how the State intends to achieve those performance goals.

3. *State Transformation Outcome Measures*

States are required to identify at least one state specific mental health transformation outcome measure and to report a performance indicator related to the measure. State specific transformation performance indicator(s) shall be constructed according to the guidance provided in this document under Item 4 of Section III: Format of Plans, and should be labeled as transformation outcome measures.

Table 4 Illustrates the National Outcome Measures:

1. The four National Outcome Measures required by the OMB PART. States are expected to incorporate these four measures along with the State-specific indicators in the FY 2007 Plan. In future years, requirements for reporting on the remaining NOMS will be phased in and updated as needed.
2. The location of the four NOMS within the five criteria.
3. The table distinguishes which NOMS are derived from the Basic Tables and Developmental Tables. Those derived from the Developmental Tables will require further collaborative work by SAMHSA and the States to specify and define the measures used to construct them. Once work on a Developmental Table is finalized through the DIG process, it is expected that States will begin reporting data and incorporating the measure into the plan. It is expected that all developmental measures will be finalized by the end of FY 2007.

Table 4.

NATIONAL OUTCOME MEASURES (NOMS)

National Outcome Measures		Relevant Criterion	DIG Tables Basic & Developmental	PART
INDICATORS EXPECTED IN 2006 OR COMPLETE STATE LEVEL DATA REPORTING CAPACITY CHECKLIST *				
1. Increased Access to Services*	Number of Persons Served by Age, Gender, and Race/Ethnicity	Criteria 2 and 3	Basic Tables 2A and 2B	Yes
2. Reduced Utilization of Psychiatric Inpatient Beds*	Decreased Rate of Readmission to State Psychiatric Hospitals within 30 days and 180 days	Criteria 1 and 3	Developmental Table 20A	Yes
3. Use of Evidence-Based Practices*	Number of Evidence-based Practices Provided by State	Criteria 1 and 3	Developmental Tables 16 and 17	Yes
	Number of Persons Receiving Evidence-based Practice Services	Criteria 1 and 3	Developmental Tables 16 and 17	Yes
4. Client Perception of Care*	Clients Reporting Positively About Outcomes	Criteria 1 and 3	Basic Table 11	Yes
INDICATORS ENCOURAGED TO BE INCLUDED IN THE STATE PLAN IF STATE HAS CAPACITY TO REPORT				
5. Increase/Retained Employment or Return to/Stay in School	Profile of Adult Clients by Employment Status	Criterion 1	Basic Table 4	No
	Increased school attendance	Criteria 1 and 3	Developmental Table 19C	No
6. Decreased Criminal Justice Involvement	Profile of Client Involvement in Criminal and Juvenile Justice Systems	Criteria 1 and 3	Developmental Table 19A and 19B	No
INDICATORS IN DEVELOPMENT				
7. Increased Social Supports/Social Connectedness	TO BE DETERMINED	Criteria 1 and 3	Developmental TBD	No
8, Increased Stability in Housing	Profile of client's change in living situation (including homeless status)	Criteria 1 and 3	Developmental Table 15	No
9. Improved Level of Functioning	TO BE DETERMINED	Criteria 1, 3, and 4	Developmental TBD	No

The selection of specific goals and targets for NOMS is determined by each State. States will also determine the goals and targets for State selected performance indicators, to include mental health transformation**.** The goal, targets, and performance indicators should be prepared for each criterion following the one-page sample in Appendix I, National Outcome Measures and State Specific Performance Indicators. For each goal, target and corresponding performance indicator included in the State plan, a similar one-page description employing the same format should be included.

4. Format of Plans

(a) Adult Mental Health Plan

(i) Current Activities

States should describe their adult mental health service system in a narrative that addresses Criteria 1, 2, 4, & 5 of Table 3 above. Narratives for each criterion should convey the extent to which the services required under the criterion have been implemented.

(ii) Goals, Targets and Action Plans

For each criterion, the plan should include goals, targets and action plans which include state specific performance indicators and state specific transformation performance indicators for adults with SMI that are useful for tracking improvements in the public mental health system within the State in addition to the NOMS discussed above. A narrative describing the State's actions toward achieving these improvements must accompany the indicators.

Further description of the construction of the indicators is shown in Appendix I. If States are unable to collect and report the data for any of the tables from which the NOMS are constructed, the State Level Data Reporting Capacity Checklist should be completed or a narrative provided that describes the State's efforts toward building capacity to collect the data and an estimated completion data. However, States are encouraged to complete and include in the plan all indicators that can be constructed from available data in the URS Tables.

For each indicator, States must show the data for the past two years (to the extent that it is available), and project a specific target for the next year (or the next two years for multi-year plans.) The most common table format for presenting indicators is provided below. Accompanying narrative describing actions the State intends to take to achieve each of its goals must also be presented. Further instructions related to preparation of performance indicators are shown in Appendix I.

Performance Indicator Table for State Plan

Name of Performance Indicator:
Population:
Criterion:
Related to Transformation ☐ **Yes** ☐ **No**

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target
Performance Indicator				
Numerator			---	---
Denominator			---	---

Table Descriptors:
Name of Performance Indicator: Brief name of the performance indicator (*e.g.*, Increased Access to Services); ***clearly label transformation outcome measures.***
Population: SED Children or name special population
Criterion: *e.g.*, "Criterion 1, Comprehensive Community-Based Mental Health Service System"
Target: a target is specific, measurable, and expected to be achieved within a defined period of time, and, if attained, is expected to contribute to the realization of the goal
Performance Indicator=Numerator divided by Denominator (except in cases where there is no denominator) and expressed as a percentage.

Columns:
(2) Actual FY2004 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(3) Actual FY2005 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(4) State projected value for this performance indicator for FY2006; **it is not necessary to include the numerator and denominator.**
(6) State target for FY2007;

(b) Children's Mental Health Plan

(i) Current Activities

States should describe their adult mental health service system in a narrative that addresses Criteria 1, 2, 4, & 5 of Table 3 above. Narratives for each criterion should convey the extent to which the services required under the criterion have been implemented.

(ii) Goals, Targets and Action Plans

For each criterion, the plan should include goals, targets and action plans which include the state specific performance indicators and state specific transformation performance indicators for children with SED that are useful for tracking improvements in the public mental health system within the State in addition to the CMHS Core Performance Indicators discussed above. A narrative describing the State's actions toward achieving these improvements must accompany the indicators.

Further description of the construction of the indicators is shown in Appendix I. If States are unable to collect and report the data for any of the tables from which the CMHS Core Performance Indicators are constructed, the State Level Data Reporting Capacity Checklist should be completed or a narrative provided that describes the State's efforts toward building capacity to collect the data and an estimated completion date. However, States are encouraged to complete and include in the plan all indicators that can be constructed from available data in the URS Tables.

For each indicator, States must show the data for the past two years (to the extent that it is available), and project a specific target for the next year (or the next two years for multi-year plans.) The Table format for presenting each indicator is presented below. Accompanying narrative describing actions the State intends to take to reach each of its goals must also be presented**.**

Performance Indicator Table for State Plan

Name of Performance Indicator:
Population:
Criterion:
Related to Transformation ☐ **Yes** ☐ **No**

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2006 Projected	FY 2007 Target
Performance Indicator				
Numerator			---	---
Denominator			---	---

Table Descriptors:
Name of Performance Indicator: Brief name of the performance indicator (*e.g.*, Increased Access to Services); ***clearly label transformation outcome measures.***
Population: SED Children or name special population
Criterion: *e.g.*, "Criterion 1, Comprehensive Community-Based Mental Health Service System"
Target: a target is specific, measurable, and expected to be achieved within a defined period of time, and, if attained, is expected to contribute to the realization of the goal
Performance Indicator=Numerator divided by Denominator (except in cases where there is no denominator) and expressed as a percentage.

Columns:
(2) Actual FY2004 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(3) Actual FY2005 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(4) State projected value for this performance indicator for FY2006; **it is not necessary to include the numerator and denominator.**
(5) State target for FY2007;

Table 5. FY 2007 MHBG Transformation Reporting Form

FY 2007 MHBG Transformation Reporting Form

State: _____

2007 Transformation Allocation Amount: _____
See Allocation Table for Transformation Funding in Appendix V.

State Transformation Activity	*MHBG Criteria*	*NFC Goal No.*	*FY 2007 MHBG Planned Expenditure Amount for Transformation **
Describe why the State identifies this activity as transformational.			

****Total should equal the FY 2007 Transformation Allocation amount stated above.***

PART D. Implementation Report

This section will contain the State Plan Implementation Report for FY 2007 as required by the PHS Act[19] States are requested to prepare and submit their implementation reports for the last completed FY in the format provided in this guidance. *This will contain a report on the purposes for which the Community Mental Health Services Block Grant monies were expended, the recipients of grant funds, and a description of block grant-funded activities.*[20] ***Should the FY 2007 budget appropriations language become law, States will be required to include BG expenditures for mental health transformation activities.*** The report shall focus on the extent to which the State has implemented its plan for the FY, with particular attention given to the goals and performance indicators. This section should also contain any comments from the mental health planning council, preferably in the form of a letter.[21] The Data Tables (presented in Part E) are considered a component of the Implementation Report. Please submit an original implementation report plus two copies to Ms. LouEllen M. Rice, Grants Management Officer, Division of Grants Management, OPS, SAMHSA, 1 Choke Cherry Road, Room 7-1091, Rockville, Maryland 20857 by December 1, 2006. As noted above, electronic submissions are allowed and should be mailed to Deborah Baldwin, Project Officer, at deborah.baldwin@samhsa.hhs.gov. If an electronic copy is submitted, two additional hard copies mentioned above must also be mailed to the Grants Management Office. Please note that if your Implementation Report is not received in the Office of Grants Management by December 1, your State will not obtain a grant for the year indicated.

I. Narrative Content of the Implementation Report

1) Report Summary

- X Areas which the State identified in the prior FY's approved Plan as needing improvement;
- X The most significant events that impacted the mental health system of the State in the previous FY; and

19. Section 1912(d)(1) of PHS Act (42 USC 300x-2)
20 As required by Section 1942(a)(1) and (2) of PHS Act (42 U.S.C. 300x-52).
21 As required by Section 1915 (a)(2) of PHS Act.

X A report on the purposes for which the block grant monies for State FY were expended, the recipients of grant funds, and a description of activities funded by the grant, ***to include Block Grant funds expended for activities for mental health transformation. See Table V.***

II. Performance Indicators

1) **Performance Indicators.** States are required to complete the Performance **Indicator Table for the Implementation Report** as presented below**.** The purpose of this table is to show data for the State-selected performance indicators and the CMHS NOMS over time. Narrative discussion of performance indicators (see discussion in Section IV) should be provided with these tables.

Performance Indicator Table for Implementation Plan

Name of Performance Indicator:
Population:
Criterion:
Related to Transformation ☐ Yes ☐ No

(1)	(2)	(3)	(4)	(5)	(6)	(7)
Fiscal Year	FY2005 Actual	FY2006 Actual	FY2006 % Attained	FY 2007 Target	FY2007 Actual	FY 2007 % Attained
Performance Indicator						
Numerator			---	---		---
Denominator			---	---		---

Table Descriptors:
Name of Performance Indicator: Brief name of the performance indicator (*e.g.*, Increased Access to Services); ***clearly label transformation outcome measures.***
Population: SMI Adult or SED Children or name special population
Criterion: *e.g.*, "Criterion 1, Comprehensive Community-Based Mental Health Service System"
Target: a target is specific, measurable, and expected to be achieved within a defined period of time, and which, if attained, is expected to contribute to the realization of the goal
Performance Indicator: Numerator divided by Denominator (except in cases where there is no denominator) and expressed as a percentage.

Columns:

(2) Actual FY2005 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(3) Actual FY2006 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(4) Percentage attained for indicator in FY 2006
(5) State Target for FY 2007
(6) Actual FY2007 value for the performance indicator, including both numerator and denominator if the performance indicator is a rate.
(7) Percent attained is equal to dividing column (6) by column (5). If less than 100%, State did not achieve its target; if greater than 100%, State surpassed its target.

III. Accomplishments

This section should be integrated with the data presentation above. For each of the targets and corresponding performance indicators, the State should provide a brief narrative containing the following information:

- X Documentation of the activities under each indicator for each criterion. This shall include data to support the State's report about its accomplishments for each target and performance indicator identified in the Plan for the prior FY. ***The documentation shall also address the State's progress and achievements toward mental health system transformation;,***
- X Description of activities and strategies the State used to address the performance indicator;
- X Any changes in the implementation strategy described in the Plan for the prior State FY;
- X Any innovative or exemplary model of mental health service delivery that the State developed, and its unique features;
- X At the end of each indicator's narrative, the report should clearly state whether or not the particular target identified in the Plan for the prior State FY for adults with SMI or children with SED was "achieved" or "not achieved"; and
- X If the targets were "not achieved," explain why.

PART E: Uniform Data on Public Mental Health System

This section guides States in the reporting of uniform data on public mental health services in the State (with special focus on community mental health services) in a series of basic and developmental data tables. The completion of Part E is a term and condition for funding for States and Territories that were awarded Data Infrastructure Grants; all States and Territories that accepted the grant agreed to submit Part E as part of the FY 2006 Implementation Report. The Report for FY 2006 is due December 1, 2006 with Part D, the Implementation Report. States and Territories that did not receive a Data Infrastructure Grant are encouraged to submit data under Part E. If a State cannot provide data in tables, the State must indicate its reporting capacity in the State Level Data Reporting Capacity Checklist. To ensure uniformity, the data reported shall be based on the data definitions agreed to in the Mental Health Data Infrastructure Project. States are requested to report data based on the last completed fiscal year.

Uniform data on the public mental health system are required to improve planning and oversight of community mental health services provided under the Community Mental Health Services Block Grant and Performance Partnerships. Block grant funds further the capacity of the publicly funded community mental health system in each state. The flexible funding of the block grant allows States to fund gap-filling, new and innovative services. To understand the value and usage of block grant funds, it is critical that both CMHS and the State Mental Health Authorities (SMHAs) have accurate and uniform data on the public mental health system in each State. Towards this end, the data requested in the tables described in this Section answer five basic questions: 1) What are the mental health service needs of the population in your State? 2) Who in your State gets access to publicly funded mental health services? 3) What types of services are being provided in your State? 4) What are the outcomes of the services provided? and 5) What financial resources are expended for the services?

All client data will be aggregated at the State level. No individual client data are requested or should be submitted. State identifiers are required for each table. CMHS, working with its contractor, the National Association of State Mental Health Program Directors (NASMHPD) National Research Institute (NRI), will create all derived measures from the primary data provided by the States. CMHS will review the State-submitted data and make requests for

revision, clarification, or additional information as appropriate from the State MHAs. After the final review and analysis of the data is completed, CMHS will make State-by-State data profiles available, as well as summary tables that examine performance across all States for selected data elements.

ATTACHMENTS

A. Federal Funding Agreements
B. Certifications
C. Disclosure of Lobbying Activities
D. Assurances
E. Face Sheet

Attachment A

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS

FISCAL YEAR 2007

I hereby certify that _____ agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

Section 1911:

Subject to Section 1916, the State[22] will expend the grant only for the purpose of:

i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:

ii. Evaluating programs and services carried out under the plan; and

iii. Planning, administration, and educational activities related to providing services under the plan.

Section 1912

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms "adults with a serious mental illness" and "children with a severe emotional disturbance" and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2007, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

21. The term State shall hereafter be understood to include Territories.

(A) Services principally to individuals residing in a defined geographic area (referred to as a "service area")
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.
(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]

(c) The State will:

(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

Section 1943:

(a) The State will:
(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2007 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2007 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

_____ _____
Governor Date

B. Certifications
http://www.mhbg.samhsa.gov/certification.pdf

C. Disclosure of Lobbying Activities
http://www.mhbg.samhsa.gov/disclosure.pdf

D. Assurances
http://www.mhbg.samhsa.gov/assurance.pdf

Attachment E

FACE SHEET

COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

_____ FY 2007

STATE NAME: _____

DUNS #: _____

I. AGENCY TO RECEIVE GRANT

AGENCY: _____

ORGANIZATIONAL UNIT: _____

STREET ADDRESS: _____

CITY: _____STATE: _____ ZIP: _____

TELEPHONE: _____ FAX: _____

II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT

NAME: _____ TITLE: _____

AGENCY _____

ORGANIZATIONAL UNIT: _____

STREET ADDRESS: _____

CITY: _____STATE:_____ ZIP: _____

TELEPHONE: _____ FAX: _____

III. STATE FISCAL YEAR

FROM: _____ _____ TO: _____ _____

Month Year Month Year

IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION

NAME:_____ TITLE:_____

AGENCY: _____

ORGANIZATIONAL UNIT:_____

STREET ADDRESS:_____

CITY:_____STATE:_____ ZIP: _____

TELEPHONE: _____ FAX: _____ EMAIL: _____

Appendix I. Format for Constructing and Reporting Performance Indicators

As described in PART C: Section III of the State Plan Guidance, in submission of the State's MH Plan, States are expected to continue to develop, maintain and report on state specific performance indicators that are useful for tracking improvements in the public mental health system within the State, in addition to incorporating the set of CMHS NOMS discussed in Section III.

The purpose of this section is to describe the construction and reporting of both types of performance indicators. The section begins with a sample table to be employed with the State Plan and a sample table to be used with the Implementation Report.

Sample Performance Indicator Table for State Plan

Name of Performance Indicator: Percentage of Inpatient Readmissions at 30 days (Reduced Utilization of Psychiatric Inpatient Beds)
Population: Adult SMI
Criterion: Criterion 1: Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)
Fiscal Year	FY2003 Actual	FY2004 Actual	FY2005 Projected	FY 2006 Target	FY 2007 Target
Performance Indicator	20%	20%	15%	15%	15%
Numerator	2,000	2,000	--	--	--
Denominator	10,000	10,000	--	--	--

This table indicates that:

Column (2) in FY2003, there were 2,000 adults who were readmitted within 30 days out of 10,000 persons discharged from a State Hospital during the past year. That yields a performance indicator of 20% readmitted.

Column (3) For FY2004 the same number of readmissions and discharges occurred resulting in a performance indicator of 20%.

Column (4) For FY 2005, it is projected that 15% of adults discharged from a State Hospital will be readmitted within 30 days.

Column (5) For FY 2006 a target of 15% is set.

Column (6) State target of 15% set for FY2007; required for multi-year plans only.

Sample Performance Indicator Table for Implementation Plan

Name of Performance Indicator: Percentage of Inpatient Readmissions at 30 days (Reduced Utilization of Psychiatric Inpatient Beds)
Population: Adult SMI
Criterion: Criterion 1: Comprehensive Community-Based Mental Health Service Systems

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Fiscal Year	FY2004 Actual	FY2005 Actual	FY2005 % Attained	FY 2006 Target	FY2006 Actual	FY 2006 % Attained	FY 2007 Target
Performance Indicator	20%	20%	100%	15%	15%	100%	12%
Numerator	2,000	2,000	---	--	1,500	---	
Denominator	10,000	10,000	---	--	10,000	---	

This table indicates that:

Column (2) in FY2004, there were 2,000 adults who were readmitted within 30 days out of 10,000 persons discharged from a State Hospital during the past year. That yields a performance indicator of 20% readmitted.

Column (3) For FY2005 the same number of readmissions and discharges occurred which resulted in a performance indicator of 20%.

Column (4) the percentage attained was 100% as reported in the FY 2005 Implementation Report

Column (5) For FY 2006, a target of 15% readmitted was set

Column (6) For FY 2006 1,500 readmissions occurred out of 10,000 discharges resulting in a performance indicator rate of 15%

Column (7) For FY 2006 the State met 100% of its goal (Column (6) divided by column (5).

Column (8) For FY 2007 a target of 12% was set (only if a multi-year plan was submitted)

Immediately following the table, there should be narrative discussion indicating whether the results are satisfactory or what actions the State plans to take to improve performance on this indicator in the future

1. CMHS NOMS

All but the developmental NOMS may be derived from the Basic or Developmental Data Tables (See Table below)... If States are unable to collect and report the data for any of the tables from which the NOMS are constructed, the State Level Data Reporting Capacity Checklist should be

completed or a narrative provided that describes the State's efforts toward building capacity to collect the data and an estimated completion date. . However, States are encouraged to complete and include in the plan all indicators that can be constructed from available data in the URS Tables.

Sources of NOMS in Basic and Developmental Data Tables.

Adult NOMS		**Table Reference**	**Numerator**	**Denominator**
1. Increased Access to Services	Adults served by gender and race/ethnicity	Basic Table 2A	Persons served over the age of 18 by gender, race/ethnicity and total.	NONE
2. Reduced utilization of psychiatric inpatient beds	Decreased rate of readmissions to State Psychiatric Hospitals within 30 days	Developmental Table 20A	Number of persons, aged 18+, who are readmitted to a State hospital within 30 days	Number of persons, aged 18+, discharged from a State Hospital during the past year
	Decreased rate of readmissions to State Psychiatric Hospitals within 180 days	Developmental Table 20A	Number of persons, aged 18+, who are readmitted to a State hospital within 180 days	Number of persons, aged 18+, discharged from a State Hospital during the past year
3. Evidence-based practices	Actual evidence-based practices provided in State	Developmental Tables 16-17	For each of eight evidence-based practices, indicate (Yes-No) whether it being provided	NONE
	Number of SMI adults receiving evidence-based practices	Developmental Tables 16-17	Number of SMI adults, aged 18+, who are receiving any of the eight evidence-based practices	NONE
4. Client Perception of Care	Clients reporting positively about outcomes	Basic Table 11	Number of positive responses reported in the outcome domain on the adult consumer survey	Total responses reported in the outcome domain on the adult consumer survey
INDICATORS ENCOURAGED TO BE INCLUDED IN THE STATE PLAN IF STATE HAS CAPACITY TO REPORT				
5. Increase/ Retained Employment or Return/Stay in School	Profile of Adult Clients by Employment Status	Basic Table 4	Number employed	Number employed plus number unemployed
6. Decreased Criminal Justice Involvement	Profile of Client Involvement in Criminal Justice System	Developmental Table 19A	Total C (number with criminal justice involvement)	Total B (number for whom data are available)

Child NOMS		Table Reference	Numerator	Denominator
1. Increased Access to Services	Children served by gender, and race/ethnicity.	Basic Table 2A	Persons served under the age of 18 by gender, race/ethnicity and total.	NONE
2. Reduced utilization of psychiatric inpatient beds	Decreased rate of readmissions to State Psychiatric Hospitals within 30 days	Developmental Table 20A	Number of persons, aged 0-17, who are readmitted to a State hospital within 30 days	Number of persons, aged 0-17 , discharged from a State Hospital during the past year
	Decreased rate of readmissions to State Psychiatric Hospitals within 180 days	Developmental Table 20A	Number of persons, aged 0-17, who are readmitted to a State hospital within 180 days	Number of persons, aged 0-17 , discharged from a State Hospital during the past year
3. Evidence-based practices	Actual evidence-based practices provided in State	Developmental Tables 16-17	Indicate whether therapeutic foster care is being provided.	NONE
	Number of SED children receiving evidence-based practices	Developmental Tables 16-17	Number of SED children, aged 0-17, who are receiving therapeutic foster care	NONE
4. Client Perception of Care	Clients reporting positively about outcomes	Basic Table 11	Number of positive responses reported in the outcome domain on the child consumer survey	Total responses reported in the outcome domain on the child consumer survey
INDICATORS ENCOURAGED TO BE INCLUDED IN THE STATE PLAN IF STATE HAS CAPACITY TO REPORT				
5. Increase/Retained Employment or Return to/Stay in School	Increased school attendance	Developmental Table 19C	Total C (number attending school)	Total B (number for whom data are available)
6. Decreased Juvenile Justice Involvement	Profile of Client Involvement in Juvenile Justice System	Developmental Table 19B	Total C (number with juvenile justice involvement)	Total B (number for whom data are available)

2. State Developed Performance Indicators

Over the past years, states have been required to develop state-specific indicators for each of the criteria for the adult and child plans. For this application, they are expected to continue to report on performance indicators that they have considered being important in tracking the progress of the public mental health system in the past, to develop new indicators, as appropriate, as well as incorporating the NOMS.

3. Administrative Goals, Targets and Indicators

Not all goals set by a State need to be immediately associated with service delivery. Some may be related to changes in the structure of the administration of the public mental health system. For example, State mental health authorities may wish to develop a mechanism to pool or blend funding for children's mental health services under the jurisdiction of multiple State and/or local government agencies, in order to promote the reallocation of resources from State inpatient care to community-based services. For objectives identified under such goals, the performance indicator might be an interagency memorandum of agreement, new statutory authority conferred by the Legislature and the Governor, or changes in regulations or contracting procedures.

States are also expected to set administrative goals and targets and to select performance indicators appropriate to them. They should be included within the most appropriate of the mental health block grant criterion. No special format is offered here. States can adapt the format for describing quantitative performance indicators for this purpose.

4. Description of Indicators

The performance indicator tables presented above should be employed to present both plans and results. The guidance below is intended to assure a common approach to describing these indicators. In addition to the performance indicator table, for each indicator there must be a fuller, more descriptive title, as well as other information about the design of the performance indicator. It is to be included following the "Format for Performance Indicator Description," presented below. This description should cover the following elements (see examples below):

X The goal of the State plan under each criterion;

X Specific, measurable objective(s) identified to reach the goal;

X The relevant population group (SMI or SED);

X The relevant mental health block grant criterion;

X Brief name for the indicator *with transformation outcome measures clearly labeled*

X Full, descriptive indicator;

X Description of the measure(s) employed to construct the indicator (i.e., contract reporting system, Medicaid claims data, recipient survey);

X Explanatory note, if any;

X Sources of information employed to obtain data for the indicator (i.e., contract reporting system, Medicaid claims, recipient survey);

X Special issues, if any; and

X Significance of the identified objective for the Community Mental Health Services program; please explain the importance of this indicator in impacting on the state system of care.

Examples of Format for Performance Indicator Description

Criterion 1 - Example A

Goal: To significantly reduce the inpatient census of State and county-operated mental health specialty facilities by placing all eligible individuals with mental illness appropriately in the community.

Target: Reduction in inpatient census of State and county operated mental health specialty facilities by another fifty individuals from the current level.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: State & county inpatient census.

Indicator: Number of patients-in-residence in State and county hospitals among persons who are SMI or SED.

Measure: This number may be either (1) the number of patients who are in residence in State and county mental health specialty hospitals at the end of the State's fiscal year OR (2) the average daily inpatient census for the State's fiscal year.

NOTE: If the State contracts out for care that formerly would have been provided in its inpatient system, patients-in-residence or daily average census for these contracts should be incorporated and explained on this indicator page. Separate performance indicators should be maintained for adults and for children. <u>For adults, States should indicate whether forensic inpatient information is included in the total.</u> In some states it may be appropriate to focus on inpatients with a civil commitment status only.

Sources(s) of Information: State hospital reporting system; contract reporting system.

Special Issues: In many States, reduced utilization of State hospital care may be the result of expanded utilization of general hospital psychiatric inpatient beds, particularly by persons who are eligible for Medicaid and Medicare. States may wish to track utilization of psychiatric inpatient care under these and other auspices. This indicator would not include persons served in residential treatment facilities. States may wish to track this utilization separately or include it under the indicator percentage of children with SED who are placed out-of-home (e.g., foster care, residential home, juvenile detention).

Significance: A major outcome of the development of a community-based system of care is expected to be reduced utilization of state and county-operated psychiatric inpatient beds.

Criterion 1 - Example B

Goal: To provide case management services for all persons who receive substantial amounts of public funds or services.

Target: Expansion of access to case management services among persons who receive substantial amounts of public funds or services by 5%.

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based mental health system.

Brief Name: Percentage receiving case management.

Indicator: Percentage of adults with serious mental illness who receive case management services among those who receive substantial amounts of public funds or services.

Measure: Numerator: The number of adult recipients with a serious mental illness who are receiving case management services during the fiscal year.
Denominator: The number of adults who receive a substantial amount of mental-health related public funds or services during the fiscal year.

Sources of Information: Contract reporting system, Medicaid management information system, SMHA client information system, and estimates of treated prevalence.

Special Issues: States must define key terms. The count of persons receiving case management might include only those enrolled in formal case management programs, or might extend to those who receive case management services in any program which offers those services in conjunction with other mental health services. States must also operationally define the concept of "adults who receive substantial amount of mental-health related public funds or services during the fiscal year". This definition will depend upon what information is most readily available to the State.

Significance: Assuring access to case management services for persons with a serious mental illness is a primary goal of the mental health block grant legislation.

Criterion 1 - Example C

Goal: To provide assertive community treatment to all eligible individuals who request it.

Target: An increase of 40 in the number of persons receiving assertive community treatment (ACT).

Population: Adults with a serious mental illness.

Criterion: Comprehensive, community-based health system.

Brief Name: Persons receiving ACT.

Indicator: The number of persons receiving assertive community treatment during the fiscal year.

Measure: Count of persons receiving services through a formal ACT program.

Sources of Information: Contract reporting, Medicaid management information system

Significance: Research evidence supports the development of ACT programs to meet the needs of persons with serious mental illness.

Criterion 2 - Example:

Goal: Expand access to mental health services for all persons who have a serious mental illness.

Target: Expansion of access to mental health services to 4% more of the population of persons with a serious mental illness.

Criterion: Prevalence and treated prevalence of mental illnesses

Population: Adults with a serious mental illness.

Brief Name: Treated prevalence of serious mental illness.

Indicator: The percentage of adults with a serious mental illness who receive mental health services during the fiscal year.

Measure: Numerator: Estimated number of adults with a serious mental illness and who have received mental health services during the fiscal year.

Denominator: Estimated number of adults who annually have a serious mental illness in the State.

Sources of Information: Numerator: State client information system, Medicaid management information system.

Special Issues: States may use the CMHS definition for "serious mental illness" and "serious emotional disturbance," and estimates of "prevalence" as an appropriate basis for planning in the public mental health system. If States adopt an alternative definition and a different estimate of prevalence, both the definition and prevalence estimation method should be carefully described and well-justified

Significance: Setting quantitative goals for the number of adults with a serious mental illness to be served in the public mental health system is a key requirement for the mental health block grant legislation.

Appendix II. Examples of Mental Health Transformation Activities

I. Examples of Mental Health Transformation Infrastructure Activities

- *Needs and resource assessment*
- *Strategic planning*
- *Coordination, alignment, pooling, and/or braiding of funding streams and other strategies for addressing financing issues*
- *Development or expansion of provider, consumer, and family networks*
- *Workforce development*
- *Communications/public awareness activities*
- *Policy formulation and implementation to support needed service system improvements*
- *Data infrastructure*

II. Examples of Mental Health Transformation Services

- *Individualized plan of care*
- *Transportation*
- *Supported Housing*
- *Supported Employment*
- *Medication Management*
- *Suicide Prevention*
- *Jail Diversion*
- *Peer Services*
- *School Based Mental Health Services*
- *Collaborative Treatment with Primary Care*
- *Co-occurring Services*
- *Intervention with Homeless Individuals*

Other examples of mental health transformation activities and services may be found under the six (6) goals of the President's New Freedom Commission on Mental Health Report. Mental health transformation services and activities should be consumer and family driven, culturally competent, recovery based, and as much as possible, utilize existing evidence-based

approaches and promising practices. Emphasis should be placed on services that are consumer controlled and consumer run.

Appendix III. Format for Table of Contents

TABLE of CONTENTS
STATE BLOCK GRANT APPLICATIONS and Plans

iv. Targeted services to rural and homeless populations
v. Management systems

2) Goals, Targets and Action Plans

Part D. Implementation Report

I. Narrative Content of the Implementation Report
II. Performance Indicators
III. Accomplishments

Part E. Uniform Data on Public Mental Health System

Basic and Developmental URS Tables

Attachments

A. Federal Funding Agreements
B. Certifications
C. Disclosure of Lobbying Activities
D. Assurances

Substance Abuse and Mental Health Services Administration

Appropriation Language

For carrying out titles V and XIX of the Public Health Service Act (''PHS Act'') with respect to substance abuse and mental health services, the Protection and Advocacy for Individuals with Mental Illness Act, and section 301 of the PHS Act with respect to program management, [$3,237,813,000] $3,165,527,000: Provided, That notwithstanding section 520A(f)(2) of the PHS Act, no funds appropriated for carrying out section 520A are available for carrying out section 1971 of the PHS Act: Provided further, That in addition to amounts provided herein, the following amounts shall be available under section 241 of the PHS Act: (1) $79,200,000 to carry out subpart II of part B of title XIX of the PHS Act to fund section 1935(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1935(b) activities shall not exceed 5 percent of the amounts appropriated for subpart II of part B of title XIX; (2) $21,803,000 to carry out subpart I of part B of title XIX of the PHS Act to fund section 1920(b) technical assistance, national data, data collection and evaluation activities, and further that the total available under this Act for section 1920(b) activities shall not exceed 5 percent of the amounts appropriated for subpart I of part B of title XIX; (3) [$16,000,000] $21,000,000 to carry out national surveys on drug abuse; and (4) $4,300,000 to evaluate substance abuse treatment programs. Notwithstanding section 1911(b) of the Public Health Service Act, a State that receives an allotment under section 1911 of the Act for the current fiscal year shall use any amount it receives in fiscal year 2007 which is in excess of what it received under such section in 1998 to support one or more of the mental health transformation activities such as the expansion of access; advancement of evidence-based practices; promotion of early assessment and treatment; and promotion of consumer- and family-driven mental health care. A State that receives an allotment under section 1911 will report annually to the Substance Abuse and Mental Health Services Administration on its use of funds and the outcomes of mental health transformation activities. (Department of Health and Human Services Appropriations Act, 2006.)

Appendix V. MHBG Allocation Table for Transformation

Center for Mental Health Services

Community Mental Health Services Block Grant Program

State / Territory	FY 1998 Actuals	FY 2007 Estimate	Difference +/- (allotted to MH transformation) $	%	Mean (Avg)	Median
Alabama	3,875,371	6,262,551	2,387,180	38%	33%	33%
Alaska	429,159	736,870	307,711	42%		
Arizona	3,870,297	8,505,426	4,635,129	54%		
Arkansas	2,232,840	3,725,765	1,492,925	40%		
California	34,513,517	55,061,465	20,547,948	37%		
Colorado	3,750,325	6,224,556	2,474,231	40%		
Connecticut	3,241,039	4,444,709	1,203,670	27%		
Delaware	730,894	754,909	24,015	3%		
District Of Columbia	596,523	771,392	174,869	23%		
Florida	12,239,345	27,115,633	14,876,288	55%		
Georgia	6,194,485	12,361,924	6,167,439	50%		
Hawaii	1,243,596	1,924,367	680,771	35%		
Idaho	1,070,863	1,773,727	702,864	40%		
Illinois	11,194,433	16,441,527	5,247,094	32%		
Indiana	6,332,808	7,805,227	1,472,419	19%		
Iowa	2,740,750	3,575,338	834,588	23%		
Kansas	2,374,949	3,183,123	808,174	25%		
Kentucky	3,670,758	5,439,376	1,768,618	33%		
Louisiana	4,376,363	6,309,615	1,933,252	31%		
Maine	1,265,584	1,716,406	450,822	26%		
Maryland	5,707,845	7,765,802	2,057,957	27%		
Massachusetts	6,360,517	8,086,241	1,725,724	21%		
Michigan	10,771,969	13,429,543	2,657,574	20%		
Minnesota	4,438,360	6,938,342	2,499,982	36%		
Mississippi	2,456,254	4,130,235	1,673,981	41%		
Missouri	4,797,839	6,982,169	2,184,330	31%		
Montana	873,926	1,238,982	365,056	29%		
Nebraska	1,300,783	2,006,208	705,425	35%		
Nevada	1,450,044	3,662,214	2,212,170	60%		
New Hampshire	1,154,144	1,624,119	469,975	29%		
New Jersey	8,090,233	11,793,701	3,703,468	31%		
New Mexico	1,426,307	2,403,117	976,810	41%		
New York	17,669,287	25,532,478	7,863,191	31%		
North Carolina	6,238,341	10,916,330	4,677,989	43%		
North Dakota	548,729	796,147	247,418	31%		

Ohio	12,772,348	14,278,769	1,506,421	11%
Oklahoma	3,049,628	4,621,617	1,571,989	34%
Oregon	3,228,481	4,840,841	1,612,360	33%
Pennsylvania	12,024,336	15,242,122	3,217,786	21%
Rhode Island	895,462	1,575,795	680,333	43%
South Carolina	3,386,545	5,653,591	2,267,046	40%
South Dakota	579,888	878,747	298,859	34%
Tennessee	4,613,933	7,896,737	3,282,804	42%
Texas	16,264,840	31,563,988	15,299,148	48%
Utah	1,579,290	2,820,006	1,240,716	44%
Vermont	611,017	780,471	169,454	22%
Virginia	6,162,479	10,238,437	4,075,958	40%
Washington	6,001,118	8,347,942	2,346,824	28%
West Virginia	1,941,957	2,506,780	564,823	23%
Wisconsin	5,001,980	7,538,575	2,536,595	34%
Wyoming	382,485	516,866	134,381	26%
State Sub-total	**$257,724,264**	**$400,740,818**	**143,016,554**	**36%**
Palau	50,000	50,000	-	0%
Marshall Islands	50,000	70,636	20,636	29%
Micronesia	102,115	148,674	46,559	31%
Virgin Islands	98,168	150,903	52,735	35%
Puerto Rico	3,396,063	5,291,584	1,895,521	36%
American Samoa	50,000	79,599	29,599	37%
Guam	128,389	215,082	86,693	40%
Northern Marianas	50,000	96,174	46,174	48%
Territory Sub-total	**$3,924,735**	**$6,102,652**	**2,177,917**	**36%**
Total States/Territories	**$261,648,999**	**$406,843,470**	**145,194,471**	**36%**
SAMHSA Set-Aside	13,771,001	21,412,530	7,641,529	36%
Unexpended Set-side[1/]		216,000	216,000	100%
GRAND TOTAL	**275,420,000**	**428,472,000**	**153,052,000**	**36%**

[1/] The PHS Evaluation Funds can only support Block Grant set-aside activities. Based on the statutory formula for this program, the set-aside activities cannot exceed 5% of the program level. Therefore, this figure represents the difference between the PHS Evaluation funds and 5% of the allowable set-aside activity level.

Basic and Developmental Data Tables

The URS Basic & Developmental Tables, Guidelines, and Data Definitions for 2005 Reporting are posted in Excel and Word versions on the SDICC site (http://www.nri-inc.org/SDICC/defsdicc.cfm). You will also find the 2005 Data Reporting Capacity Checklist on this site.

The only changes for 2005 not included on the 2005 tables are the EBP guidance on reporting that the EBP workgroup has been developing. This guidance will not change the definitions, but will provide more instructions and examples of when to count a state's service as an EBP service. The additional EBP guidance will be sent to states as soon as they are final.

You will also find on the SDICC website the SMI and SED Prevalence Estimates that have been updated using the latest U.S. Census Bureau population data. These are used for URS Table 1 and may be helpful in completing the MHBG Application.